

DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection 103 South Main Street, Ladd Hall Waterbury, VT 05671-2306 http://www.dail.vermont.gov Voice/TTY (802) 871-3317 To Report Adult Abuse: (800) 564-1612

Fax (802) 871-3318

April 3, 2012

Ms. Meagan Buckley, Administrator Berlin Health & Rehab Ctr 98 Hospitality Drive Barre, VT 05641-5360

Provider #: 475020

Dear Ms. Buckley:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **February 29, 2012**. Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN, MS

**Licensing Chief** 

PC:ne

**Enclosure** 



				Fax	80224123	348	Mar 14 2012	<b>03:06pm</b> P0	05/016
		AND HUMAN SERVICES  & MEDICAID SERVICES		•		:		. FORM	; 03/14/2012 APPROVED
	T OF DEFICIENCIES		T						0938-0391
AND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	MULTIPI ILDING		RUCTION	·	(X3) DATE S COMPLI	
		475020	B. WE	NG		,	·		C
NAME OF	PROVIDER OR SUPPLIER			Τ				U2/2	9/2012
	HEALTH & REHAB C	TR		98	HOSPITA NRE, V	LITY DRIVE	ATE, ZIP CODE	. 1	′.
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREF	1 <b>X</b>	(EA	CH CORRECT SEREFERENCE	LAN OF CORRECTIVE ACTION SHO CED TO THE APPR FICIENCY)	ULD BE	(X8) COMPLETION DATE
F 000	INITIAL COMMENT	'S	F	pdo		:		•	
•	was conducted by t	n-site complaint investigation he Division of Licensing and 12. The following are the				•			
F 201 SS≕G	483,12(a)(2) REAS	ONS FOR IARGE OF RESIDENT	F;	201	1.	~	t #1 no sides at the		
	the facility, and not it resident from the fa	minite each resident to remain in transfer or discharge the clifty unless the transfer or early for the resident's welfare	•	· 1	2.		lents with a plan have		
	and the resident's n facility;	eeds cannot be met in the	,		`.	affected l	by this		
	the resident's health	harge is appropriate because in has improved sufficiently so er needs the services lity,			3.	unable or	dent who is unwilling or at time of		·
	The safety of Individend					discharge evaluated		•	
	otherwise be endan	-1.				The thera departme	py nt will	,	
	: appropriate notice, t : under Medicare or N : For a resident who b	led, after reasonable and o pay for (or to have paid ledicaid) a stay at the facility. Decomes eligible for Medicaid			4.	if needed Recduca	tion of the		
	charges under Medi	, i	,				Il be d to include		
	The facility ceases to	operate.				evaluation resident p		P	$\frac{\omega}{2}$

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

This REQUIREMENT is not met as evidenced

TITLE

discharge or when a

significant change in

2. Cerum Re

Any deficiency statement ending with an asterick (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other eafequants provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 designations are disclosable 14 program participation.

Fax 8022412348

Mar 14 2012 03:06pm P006/016

PRINTED:	03/14/2012
FORM A	PPROVED
OMP NO	1028 0204

CENTE	RS FOR MEDICARE	& MEDIÇAID SERVICES	-,			0938-0391	
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(CZ),MUL	LTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		475020	B"MMG			C 9/2012	
	PROVIDER OR SUPPLIER HEALTH & REHAB C	TR	3	TREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05641	, v	OLU II	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	ULD BE	(XS) COMPLETION DATE	
F 201	facility failed to ens appropriate becaus improved sufficient needed services prapplicable resident include:  Per record review a of Nursing (DNS) o. 2/3/12 the Admission Resident #1 states: assist of one, Commalker device and on Nursing Discharge today home with his services. Resident from bad to wheeled drowsy, non responding the MD (physician) resident's condition.  Per staff interview of Nurse (LPN) on 2/2 DNS present during was discharged on exiting the building, was very drowsy. Thursing Assistant) him from the bed to	ew and record review, the ure that a discharge was e the resident's health y so the resident no longer ovided by the facility for one (Resident #1). Findings and confirmed with the Director of 2/29/12 at 2:03 PM, the on Nursing Evaluation for "Mobility: Ambulates with a one assist". The 2/21/12 Note states, "Discharged soon and home health did not participate in transfers hair or wheelchair to car. Very sive. PT [Physical Therapy] on, the DNS confirmed that was not informed of the at time of discharge.  with a Licensed Practical 9/12 at 2:45 PM (with the interview), Resident #1 2/21/12 at 11:00 AM. Prior to s/he stated that Resident #1 the LPN and LNA (Licensed and to "pick hirt up to move the wheelchair". The LPN	F 20	mobility is noted.  5. Random weekly audits to be completed by DNS or designed to measure effectiveness of plantstart by 3/29/12.  6. The DNS to report results of plan to QAA committee monthly X 3. QAA committee to determine frequency of surveillance after this time.  7. Corrective action shall be complete by 3/29/12.		2 mgr	
,	stated s/he informed resident was very di commands. The LP with the discharge, transported the resident	the Unit Manager that the rowsy and not responding to N was directed to proceed					

Mar 14 2012 03:07pm P007/016

QE 91

PEPARTMENT OF HEALTH CENTERS FOR MEDICARE	, , , , , , , , , , , , , , , , , , , ,		PRINTED: 03/14/201 FORM APPROVE OMB NO. 0938-039
ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION	IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A BUILDING	(X3) DATE SURVEY COMPLETED
	475020	B, WING	C

		475020	B. WING		02/29/2012		
	PROMIDER OR SUPPLIER	rR		REET ADDRESS, CITY, STATE, ZIP CODE 96 HOSPITALITY DRIVE BARRE, VT 05641			
(X4) ID FREFIX TAG	; (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(XI) COMPLETION DATE	
F 201	transferring from the	s wheelchair to the car. The	F 201		•		
	was told to contact how they transfer the up the resident and. The resident's son swas going to transfer the house. After refinitionmed the Unit M	It Manager a second time and Physical Therapy concerning the resident. The LNA picked pivoted him/her into the car. I stated he did not know how he car to the resident from the car to turning to the facility, the LPN lanager that s/he did not think ould have been discharged.		Focaces Focaces	tel pe	)	
	Central Vermont Me Emergency Departr states: "Diagnosis I Status: Patient statu The caregiver found chair and unrespons	f documents obtained from edical Center, the 2/21/12 nent Physician Summary Primary: Dehydration: Patlent is is critical; Chief Complaint: I [Resident #1] half off the sive so called EMS					
	Maximum severity is are severe". Per re Emergency Departr History and Physica Complaint: unrespo	s severe, currently symptoms cord review of the 2/21/12 ment Physician Summary il, Resident #1's, "Chief nsive": Clinical Impression; epletion and sodium is					
	markedly elevated a #1] will be admitted Unit] as a full admis	it 156", Disposition: [Resident to the ICU [Intensive Care					
F 281 96=G	Also see F281 483,20(k)(3)(i) SER PROFESSIONAL S	VICES PROVIDED MEET TANDARDS	F 281	1 001	٠,		
	The services provide must meet profession	ed or arranged by the facility onal standards of quality.		PUC aco	my	ru	

This REQUIREMENT is not met as evidenced

CENTERS FOR MEDICARE & MEDICAID SERVICES

Fax 8022412348

Mar 14 2012 03:07pm P008/016

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(XZ) MULTIPU	E CONSTRUCTION	()CO) DATES COMPLE	ETED	
		475020	B. WING			C 19/2012
	PROVIDER OR SUPPLIER HEALTH & REHAB C	TR	98	ET ADDRESS, CITY, STATE, ZIP COD HOSPITALITY DRIVE IRRE, VT. 06641		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL BC DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(XS) CUMPLETION DATE
F 281	by: Based upon intervipilled to meet profe 1 applicable reside Physician concerning reading; 2) Failing Resident was very the time of dischar Resident's Intake a (Resident #1) In a an admission to an hospital, the same facility for dehydrat  Per record review Nursing Notes and pressure readings with the Director of 1:27 PM, the Resid documented as 88 report the low BP t not assess Reside Pressure, Measuri readings. Per rev "Blood Pressure, A defined as blood p mm/hg. The policy should be reported should record seve day, including beforeview and confirm 1:27 PM, there is n BP readings per Fa and the 2/18/12 ni is oriented to name commands.	iew and record review, staff essional standards of quality for int by: 1) Failing to notify the ing a low blood pressure to notify the Physician that the drowsy and unresponsive at ge; and 3) Not monitoring the ind output when indicated. didition, Resident #1 required intensive Care Unit at a local day as discharge from the tion. Findings include; of the Physician Orders, documentation of blood for Resident #1, and confirmed Nursing (DNS) on 2/29/12 at dent's Blood Pressure (BP) was 1/48 on 2/18/12. Staff did not of the Physician (MD) and did int #1 per Facility policy. Blooding for low blood pressure dew of the Facility policy. Ressuring Hypotension (states that hypotension to the physician and that staff or it readings throughout the read after meals. Per record red with the DNS on 2/29/12 at the documentation of additional acility Policy for Resident #1 ursing note states Resident #1 ursing note states Resident #1 and unable to follow simple	F 281	<ol> <li>Resident #1 no longer resides at the center</li> <li>Any blood pressur indicative of hypotension will be reported to the physician as per policy.</li> <li>Any significant change in transfer ability and/or unresponsiveness be reported to the physician.</li> <li>All residents will have dietician assessment for fluid/meal requirements. Deviations from the fluid requirement below 1200cc/24 hours will be reported to the unit manage or designee for follow up with the physician and the dietician if necessars.</li> <li>Nurses will be</li> </ol>	will  ted rs  P  ary.  A  T  C	281 Crester umog B
	Per record review	and confirmed with the Director		reeducated regardi	ng	

Mar 14 2012 03:07pm P009/016

PRINTED: 03/14/2012 FORM APPROVED

		& MEDICAID SERVICES	•			APPROVED 0938-0391	
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ),MI	ULTIPLE CONSTRUCTION LDING	(X3) DATE SURVEY COMPLETED		
	· •	475020	B. WIN	10	C 02/29/2012		
NAME OF P	ROVIDER OR BUPPLIER		1	STREET ADDRESS. CITY, STATE, ZIP CODE			
BERLIN	HEALTH & REHAB C	TR		98 HOSPITALITY DRIVE BARRE, VT 05641	•		
(X4) ID PREFIX TAG	(PACH DEFICIENC)	ITEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	(D PREFI TAG		OULD BE	COMPLETION DATE	
F 2B1	2/3/12 the Admission Resident #1 states: assist of one; Communities and of Nursing Discharge	n 2/29/12 at 2:03 PM, the on Nursing Evaluation for "Mobility: Ambulates with ments: Ambulates with a one aasist". The 2/21/12 Note states, "Discharged	F2	pressures, I&O requirements, and procedure to be followed when a resident is non-			
	services. Resident from bed to wheeld drowsy, non respor informed." In addit the MD (physician)	s son and home health did not participate in transfers hair or wheelchair to car. Very sive. PT [Physical Therapy] ion, the DNS confirmed that was not informed of the at time of discharge.		responsive or experiences a significant change of transfer status. 6. Random weekly audits to be	n		
	Nurse (LPN) on 2/2 Nursing present du resident was dische Prior to exiting the resident was very of (Licensed Nursing to move him from the The LPN stated s/r that the resident was responding to comit to proceed with the LNA transported th	with a Licensed Practical 19/12 2:45 PM (with Director of ring the interview), the arged on 2/21/12 at 11:00 AM. building, s/he stated the browsy. The LPN and LNA Assistant) had to "pick him up he bed to the wheelchair", he informed the Unit Manager as very drowsy and not mands. The LPN was directed discharge. The LPN and he resident to the car via		completed by DNS designee to measure effectiveness of pla start by 3/29/12. 7. The DNS to report results of plan to QAA committee monthly X 3. QAA committee to determine frequence of surveillance afte	e n		
	wheelchair and the them in transferring car. The LPN notifies time and was told to concerning how the LNA picked up the in the car. The resknow how he was girding the car to the returned to the facilities.	resident was unable to assist from the wheelchair to the led the Unit Manager a second to contact Physical Therapy by transfer the resident. The resident and pivoted him/her ident's son stated he did not poing to transfer the resident house. When the LPN lity, s/he told the Unit Manager ink the resident should have		this time.  8. Corrective action shall be complete b. 3/29/12.		neil	

Mar 14 2012 03:07pm P010/016

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

TATEMENT OF DEFICIENCIES

(X1) PROVIDER/BUPPUER/CLIA

(X2) MULTIPLE CONSTRUCTION

(X3) DATE SURVEY

		A THE WALL WINDS				ONID INO.	0936-0391	
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/BUPPLIER/CLIA IDENTIFICATION NUMBER;	(X2), N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	;	475020	B, WII	۸G _		C 02/29/2012		
NAME OF F	PROVIDER OR SUPPLIER		<del>,                                    </del>	r		UAIX.	BI KU I Z	
	HEALTH & REHAB C	TR	STREET ADDRESS, CITY, STATE, ZIP C 98 HOSPITALITY DRIVE RARRE VT 05941			ODE		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		FROM DEDECTION OF CORDE	TIOU	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREF	ΙX	FROMDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	HULD BE	COMPLETION DATE	
F 281	Continued From pa	age 5	Er	104				
,	been discharged.		F	201	•			
	!						, .	
•	Per record review a	and confirmed during Interview	• 1		l .		l	
	with the Director of	Nursing (DNS) on 2/29/12 at					ľ	
	1:10 PM, Resident	#1 was not on Intake and		•	•			
	Output manitoring.	Per facility policy "Resident			•			
	Hydration and Prev	ention of Dehydration, "The					•	
	dietician will assess	s all residents for hydration	. '					
	adequact of location	marterly and more often as						
	Recessor nor mail	dent need. Minimum fluid			,	•		
-	beaga agil he salor	Sant freed. Minimum mum mud						
' '	Interior and the column	lated and documented on			•			
'	and assessment	nursing will assess for signs			· ·		'	
	and symptoms of d	ehydration during physical	1					
	care, and ir potention	al inadequate Intake and/or		i			,	
	aigns or symptoms	of dehydration are observed,	', '			,		
•	intake and output n	nonitoring will be initiated and				•	ļ	
	incorporated into th	e care plan, the distician,			,			
	nursing staff and th	e physician will assess factors	•			1	į	
	that may be contrib	uting to inadequate fluid				' '	•	
	intake.			1		. :		
	•			ľ			. 1	
	Per record review of	of the 2/14/12 nursing notes			'		. 1	
	and confirmed with	the DNS on 2/29/12, the		'			-	
	resident had 3 loos	e stools on 2/14/12 and						
'	Norovirus (gastroin	testinal illness) was present in						
'	the facility on this di	ate. Per record review of the			• • • •	· į	Ì	
	Follow Up Question	Report: What percentage of		i		1		
	the meal was eaten	for Resident #1 and		'			ļ	
!	confirmed with the I	Registered Dietician on		. 1		'		
	2/29/12 at 11-10 AL	A, from 2/3/12 to 2/10/12	'	i	- 101			
	(ending at 4:30 DEA)	Resident #1 consumed 19		ا ،	F 281 PUC acres T. Cumm	C.1	ĺ	
- 1	meals At 17 Af the	se 19 maals, the resident		. [	- none	eu.	. )	
i	COnsumed less than	of the meal. From			POC WOO		, · . · · · · · · · · · · · · · · · · ·	
	2/10/12 (etarting at	2:40 PM) to 2/21/12, the	1		, ,	- nu	,	
	resident concurred	33 meals. The resident			1. Curun	$\mathcal{L}$	- 1	
Į,	refliged 7 of 22 man	ob means. The resident			. ( Z	ا َيج		
	the merident man	als, and for 23 of 33 meals,				2	1	
	mic icoiddiit cought	ned less than 50% of the	1			,	1	
	meal.			.		· .	ì	
		'			•		ŀ	

Mar 14 2012 03:07pm P011/016

		LAND HUMAN SERVICES  & MEDICAID SERVICES	, , ,		FORM	: 03/14/2012 APPROVED : 0938-0391	
STATEMENT	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X3) DATE SURVEY COMPLETED		
	,	475020	B. WIN	G	C 02/29/2012		
NAME OF P	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE			
BERLIN	HEALTH & REHAB C	TR		98 HOSPITALITY DRIVE BARRE, VT 05641	•		
(X4) IÓ PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTIVE ACTION SH	OULD BE	(XX) COMPLETION DATE	
120				DEFICIENCY)	NOTRINIE	1	
		1				1-	
F 281	Continued From pa	ige 6	F2	81	u)		
		of documents obtained from		·	•	1	
	Central Vermont M	edical Center, the 2/21/12				İ	
	Emergency Depart	ment Physician Summary		•		j	
		Primary: Dehydration, Patient	·	C 381	•		
		us is critical; Chief Complaint: d [Resident #1] half off the		F381 Parist	^	1	
		isive so called EMS		noc.	$\mathcal{L}$	i )	
•		al Services); Seventy:	l i	assist	· -	PA	
		is severe, currently symptoms			$\sim$	100	
	are severe".	o develo, our dinny aymptoms		1. W	0		
		of the 2/21/12 Emergency	•	,			
	Department Physic	ian Summary History and	•		•	'	
		#1's, "Chief Complaint;		<b>†</b>		į.	
į	unresponsive"; Clin	ical Impression: significant			•		
,		nd sodium is markedly				1	
		Disposition; [Resident #1] will		· • • • • • • • • • • • • • • • • • • •			
		CU [Intensive Care Unit] as a	٠, ١		•		
	full admission".						
	Alon one Mos == 4	207	•				
E ann	Also see F201 and		· '			1 .	
רו שטים יין	HIGHEST WELL B	CARE/SERVICES FOR	F 3	09 1. Resident #1 no			
აა <b>-</b> ∪ !	HOTILOT WELL D	LING		longer resides in the			
,	Each resident must	receive and the facility must		center.		2 0	
	provide the necessar	ary care and services to attain			6	1301	
:	or maintain the high	rest practicable physical.		2. Any resident with			
	mental, and psycho	social well-being, in	•	hearing impairment	$ $	20,40	
•	accordance with the	comprehensive assessment	•	or lack of a hearing		agente	
	and plan of care.	**		device have the	,   A	certil	
				potential to be		1 Cum	
	• • •			affected by this		7.W.	
ļ	This REQUIREMEN	NT Is not met as evidenced					
· i	by:	41 is not trief as extraguesed	1	alleged deficient			
ļ		ew and record review, the		practice.		1 .	
	facility failed to prov	de the necessary care and		3. The care plans of all			
l l	continue to attain as	spaning of the birth and		recidenta' will be		l	

Fax 8022412348

Mar 14 2012 03:08pm P012/016

STATEMENT OF DEFICIENCIES UND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MUL	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
,	476020		B. WING		C 02/29/2012		
• •	ROVIDER OR SUPPLIER HEALTH & REHAB (		` <b>\</b>	TREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, V.T. 05841	UZIZIZUTZ		
(XA) ID PREFIX TAG	REACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LBC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION 8 CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION		
	well-being for one developing an intercommunication de includes:  Per interview with confirmed on 2/29 interim care plan recommunication de and loss of hearing confirmed on 2/29. Admission Nursing documented their Per record review Note and confirmed on the interview Note and confirmed on the art Central Vermon During the interview hearing aid was refacility and it was with the resident and the aring aid.	al, mental, and psychological applicable resident by not rim Plan of Care related to a ficit. (Resident #1). Finding.  Director of Nursing (DNS) and /12 at 3:04 PM, there was no elated to Resident #1's ficit which included deafness g aid. In addition, the DNS /12 at 2:10 PM that the g Assessment dated 2/3/12 esident has profound deafness of the 2/22/12 Social Service ad during interview with the 2/29/12 at 2:34 PM, Residenting and left hearing aid was lost in Medical Center (CVMC), we, the Social worker stated the challenging for staff to work lince s/he did not have a	F 30	if a hearing impairment is a problem, the impairment is note on the care plan.  4. Nurses will be reeducated to incluhearing impairment on the resident carplan.  5. Random weekly audits to be completed by DNS designee to measureffectiveness of plastart by 3/29/12.  6. The DNS to report results of plan to QAA committee	d POC Turb ande at e		
	483.26(I) MAINTA UNLESS UNAVO Based on a reside assessment, the resident - (1) Maintains acc status, such as be unless the reside demonstrates tha	ent's comprehensive acility must ensure that a acility must ensure that a act and protein levels, are condition at this is not possible; and erapeutic diet when there is a	F-992	monthly X 3. QA. committee to determine frequen of surveillance afte this time. 7. Corrective action shall be complete 1 3/29/12.	cy		
	1.	•	<u> </u> 				

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Mar 14 2012 03:08pm P012/016

CENTERS FOR MEDICARE & MEDICAID SERVICES						OWB NO. 0838-0391			
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	''	(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED		
·	· · · · · · · · · · · · · · · · · · ·	475020	B. WING		C 02/29/2012				
•	ROVIDER OR SUPPLIER HEALTH & REHAB	<del>-</del>		98 j	ET ADDRESS, CITY, STATE, ZIP CODE HOSPITALITY DRIVE RRE, V.T. 05841				
(X4) 1D PREFIX TAG	. (ÈACH BEFICIEN	TATEMENT OF DEPICIENCIES CY MUST BE PRECEDED BY FULL (LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX	FROVIDER'S PLAN OF CORRECTIVE ACTION SH (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	DULID BE	(X5) COMPLETION DATE		
. F 309	Continued From	nage/7	F:	309		- 1			
1 303	practicable physic	cal, mental, and psychological e applicable resident by not erim Plan of Cara related to a			. 6	· .	-7.		
·		effeit. (Resident #1). Finding.	,		F309 poc	asunt	n		
	confirmed on 2/2 interim care plan	n Director of Nursing (DNS) and 9/12 at 3:04 PM, there was no related to Resident #1's			1.	Cum	)		
	and loss of hearl confirmed on 2/2	eficit which included deathers of aid. In addition, the DNS 9/2 at 2:10 PM that the				• •			
	documented the Per record review	ng Assessment dated 2/3/12 resident has profound deniness, v of the 2/22/12 Social Service and during interview with the	},						
,	Social Worker or   #1 is hard of hea   at Central Vermo	n 2/29/12 at 2:34 PM, Resident ring and left hearing aid was lost ant Medical Center (CVMC). low, the Social worker stated the	,			•			
	hearing aid was facility and it was	missing upon admission to the schallenging for stall to work since s/ne did not have a				,			
	. 7	AIN NUTRITION STATUS DIDABLE	F	325	<ol> <li>Resident #1 no longer resides in the</li> </ol>				
•	absessment, the resident -	ent's comprehensive facility must ensure that a			center. The resident did not experience weight loss during	1 F3	25.		
•	status, such as b unless the reside demonstrates tha	eptable parameters of nutritional ody weight and protein levels, onto clinical condition at this is not possible; and erapeutic dist when there is a m.		. '	the stay at the center  2. All residents have the potential to be affected by this alleged deficient	te Po	repeat		
, `		•	Ì		practice.	,			

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DEPARTMENT	OF HEALTH	AND HUMAN	<b>SERVICES</b>
CENTERS FOR			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A BUILDING		(X2) DATE SURVEY COMPLETED		
	, , ,	475020	B, WING		C 02/29/2012	
	PROVIDER OR SUPPLIER HEALTH & REHAB	<b>'</b> .		STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BARRE, VT 05841	<del></del>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUSY BE PRECEDED BY FULL LSC IDENTIFYING INPORMATION)	ID PREFTX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION	
F 325	by:	ENT is not met as evidenced	F 32	3. All resident's recor will be audited for complete dietician assessment includir estimated nutrient	a   .	
• •,	Assessment for o includes the estin	view and record review, the employee a Nutritional ne applicable resident which nated needs for calories and sion and prior to discharge ndings include:	,	needs for calories a fluid. The dietician will continue to recommend supplements based her assessment of	Pooling	
·· .	Progress Note an 2/9/12 and confirm Dietician (RD) on #1's nutritional as did not include the calones or fluids.	of the Registered Dieticlans d Nutritional Assessment dated ned with the Registered 2/29/12 at 11:38 AM, Resident sesament was incomplete and a estimated nutrient needs for Per interview on 2/29/12 at		needs.  4. Dietician will be reeducated on facil policy for completi dietician assessment of the reeducated of the reeducated on facil policy for completi dietician assessment of the reeducated of the reeducate	ity ng	
	surveyor, that Re- requirement is 16	culated, per request of the sident #1's daily fluid 48 cc fluid per day based upon thes and recorded weight of 145		audits to be completed by Regional RD or designee to measur	e	
	Registered Dietici AM, the 'Follow U percentage of the consumed 19 me (ending at 1:39 Pl resident consume From 2/10/12 (sta resident consume	and confirmed with the sn (RD) on 2/29/12 at 11:38 p Question Report: What meal was eaten', Resident #1 als from 2/3/12 to 2/19/12 M). At 12 of those 19 meals, the diess than 50% of the meal. Iting at 2:40 PM) to 2/21/12, the dis3 meals. The resident		effectiveness of plastart by 3/29/12. 6. The DNS to report results of plan to QAA committee monthly X 3. QAA committee to	un	
·	the resident consi meal. In addition, for Resident #1 s	eals, and for 23 of 33 meals, imed less than 50% of the the 2/9/12 RD Progress Note tates "Nutrition assessment PO all fair with approximately 2/3 of		determine frequence of surveillance afte this time.		

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MUI	14 ZOIZ OS DOPIN TOTATO
	PRINTED: 03/14/2012
	FORM APPROVED
	OMB NO. 0938-0391

CENTE	RS FOR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-0391
	r of deficiencies of correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
٠.		475020	B. WING_		C 02/29/2012
	ROVIDER OR SUPPLIER HEALTH & REHAB C	TR	9	REET ADDRESS, CITY, STATE, ZIP GODE 18 HOBPITALITY DRIVE BARRE, VT 05641	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CONRECTIVE ACTION BI CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETION
F 325	admission noted, a resident adjusts/red that at the 2/16/12 for all residents wa interdisciplinary me	age 9 creased appetite prior to expected to improve as as expected. Also, the RD stated Weight Meeting, food refusal is noted and discussed at the eting and no dietary ordered for Resident #1.	F 325	7 Corrective action shall be complete b 3/29/12.	So Samuel James
F 327 SS=G	Also see F327 483.25(j) SUFFICIE HYDRATION	ENT FLUID TO MAINTAIN  ovide each resident with	F 327	1. Resident #1 no longer resides in th center. Resident did	e I
	sufficient fluid intak and health.  This REQUIREMED by: Based upon Intervifacility failed to assimicate individual needs, wan Intensive Care I same day as dischadehydration. (Resi	e to maintain proper hydration  NT is not met as evidenced  few and record review, the ure that 1 applicable resident amount of fluids based upon the frequired admission to Juit at a local hospital the arge from the facility for dent #1). Findings include;		not experience weights loss during the stay the center.  2. All residents with decreased fluid intained due to a change in condition have the potential to be affected by this alleged deficient practice.	ke Roused Curves
	Prevention of Dehy interview with the D 2/29/12 at 1:10 PM will assess all resid least quarterly end resident need. Min calculated and documents nursing assessment, nursing the previous assessment, nursing the previous assessment and previous assessment assessment assessment and previous assessment assessment assessment assessment assessment assessment as a previous as	Resident Hydration and dration" end confirmed during lirector of Nursing (DNS) on the policy states the dictician ents for hydration adequacy at more often as necessary per Imum fluid needs will be Imented on initial g will assess for signs and ration during physical care,		3. Minimum fluid inta will be determined the dietician as per the assessment.	, , , , , , , , , , , , , , , , , , , ,

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PRINTED: 03/14/2012 FORM APPROVED

DEPARTMENT	OF HEALTH AND	<b>HUMAN SERVICES</b>
CENTERS FOR	MEDICADE PARE	TOTALO CEDUTÓES.

OMB NO. 0938-0391 -EKO LOK MEDICAKE & MEDICAID SEKVICE STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: AND PLAN OF CORRECTION COMPLETED A. BUILDING C' B. WING 475020 02/29/2012 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 98 HOSPITALITY DRIVE BERLIN HEALTH & REHAB CTR **BARRE, VT 05641** SUMMARY STATEMENT OF DEFICIENCIES (XA) ID PREFIX PROVIDER'S PLAN OF CORRECTION (XS) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COMPLETION DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY 4. All resident F 327 Continued From page 10 F 327 nutritional and if potential inadequate intake and/or signs of assessments will be symptoms of dehydration are observed, intake Po Cumy 6 and output monitoring will be initiated and audited to ensure incorporated into the care plan, the dietician. completion of nursing staff and the physician will assess factors nutrition and fluid that may be contributing to inadequate fluid intake requirements. intake. 5. Intake documentation Penrecord review of the Registered Dieticians will be initiated as Nutritional Assessment dated 2/9/12 and . per center policy and confirmed with the Registered Dietician (RD) on 2/29/12 at 11:38 AM, Resident #1's nutritional procedure. assessment was incomplete and did not include 6. Residents on intake the estimated nutrient needs for calones or fluids: monitoring will be During the interview, the RD stated s/he dld not evaluated for update the nutritional assessment upon dehydration if the admission and prior to discharge. The RD stated that Resident #1's food and fluid requirements minimum fluid intake were not calculated during the resident's stay. is not maintained for Per Interview on 2/29/12 at 12:05 PM the RD 3 days and the calculated, per request of the surveyor, that Resident #1's daily fluid requirement is 1648 cc residents has a fluid per day based upon a height of 69 inches condition where fluid and recorded weight of 145 pounds. . loss is anticipated. 7. Supplements will Per record review of the nursing notes and confirmed with the DNS on 2/29/12, Resident #1 continue to be had 3 loose stools on 2/14/12 and Norovirus recommended as per (gastrointestinal illness) was present in the facility the dietician on this date. assessment of Per record review and confirmed with the nutritional needs. Registered Dietician (RD) on 2/29/12 at 11:38 8. Nurses will be AM, the Follow Up Question Report: What reeducated on the percentage of the meal was eaten', Resident #1 policy and procedure consumed 19 meals from 2/3/12 to 2/19/12 (ending at 1:39 PM). At 12 of those 19 meals, the for Intake resident consumed less than 50% of the meal. implementation.

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		I AND HUMAN SERVICES  & MEDICAID SERVICES	•		•	FORM	03/14/2012 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(XX) MULTIPLE CONSTRUCTION A BUILDING			OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED		
	475020		B. WING		C 02/29/2012		
NAME OF F	PROVIDER OR SUPPLIER		· . ·	BTRE	EET ADDRESS, CITY, STATE, ZIP CODE		<u> </u>
BERLIN	HEALTH & REHAB C	rr		- 98	HOSPITALITY DRIVE ARRE, VT 05841	1	i.
(X4) 1D PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	PREF		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	COMPLETION DAYE
F 327	From 2/10/12 (start resident consumed refused 7 of 33 menths resident consumed. In addition, for Resident #1 start (oral) intake overall meals at 25%; Declared admission noted, e resident adjusts/resident at the 2/16/12 to rall residents was interdisciplinary me supplements were at the part record review of the part record re	ing at 2:40 PM) to 2/21/12, the 33 meals. The resident also and for 23 of 33 meals, ned less than 50% of the the 2/9/12 RD Progress Note fes "Nutrition assessment: PO fair with approximately 2/3 of reased appetite prior to expected to improve as as overs." Also, the RD stated Neight Meeting, food refusal inoted and discussed at the eting and no dietary ordered for Resident #1.	F	327	dehydration evaluation and documentation.  9. Random weekly audits to be completed by DNS designee to measure effectiveness of pla start by 3/29/12.  10. The DNS to report results of plan to QAA committee monthly X 3. QAA committee to determine frequency	, ()	27 J. Cur
	Emergency Departs states: "Diagnosis   Status: Patient state The caregiver found chair and unrespon! [Emergency Medica Maximum seventy is are severe", Per record review of Department Physical, Resident surresponsive"; Clini volume depletion are elevated at 156"; D	edical Center, the 2/21/12 ment Physician Summery Primary: Dehydration; Patlent is la critical; Chief Complaint: I [Resident #1] half off the sive so called EMS I Services]; Severity: Is severe, currently symptoms of the 2/21/12 Emergency an Summary History and It's, "Chief Complaint cal Impression: significant id sodium is markedly isposition: [Resident #1] will CU [Intensive Care Unit] as a			of surveillance after this time.  11. Corrective action shall be complete by 3/29/12.		